

Patient Registration Form

For Office Use Only: Account #: _____

Mr./Ms. _____
Last First M.I.

Address: _____
Street (or P.O. Box) City State Zip

Home Phone: (____) _____ Work Phone: (____) _____ Other (____) _____

Email address: _____ Social Security #: _____

Birthdate: _____ Age: _____ Sex: M F Primary Care Physician: _____

Marital Status: S M D W Patient Occupation: _____

Employer: _____ Employer Address: _____

How were you first referred to our office? Friend: _____ Physician: _____

Web site: ____ Yellow Pages: ____ Print Ad: ____ TV/Radio: ____ Medical Association: ____ Other:- _____

Is the patient covered by medical insurance for this procedure? YES* NO

*We will make a copy of your insurance card.

Is this a job-related injury? YES NO If yes, date of injury: _____

Medicare Patients only: Supplemental Insurance is provided by: Patient ____ Employer ____

Emergency Contact: _____
Name Phone # Relation to Patient

Person (if other than patient) Responsible for Charges Not Paid by Insurance:

Mr./Ms.: _____
Last First M.I. Relation to Patient

Address: _____
Street (or P.O. Box) City State Zip

Home Phone: (____) _____ Work Phone: (____) _____ Email Address: _____

Social Security # _____ Occupation: _____

Employer: _____ Employer Address: _____

The above information is true to the best of my knowledge. I understand I am responsible for charges associated with medical services and agree to pay all bills within 30 days of receipt of statement, unless other arrangements are made. I authorize the physician and clinic to release any information to process insurance claims and perform internal quality and peer review processes. If my procedure is billed to my insurance I agree to authorize direct payment to the physician. I consent to have medical photographs by the physician.

Patient Signature

Date

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